

FILED SEP 12 1941

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 2953

1. PLACE OF DEATH:

(a) County. Jackson
(b) City or town. Leeds, Mo.
(c) Name of hospital or institution: Kansas City Tuberculosis Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 7 mos.
In this community. 7 mos.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Josephine Steffins

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased Sept 28 1914
(Month) (Day) (Year)

8. AGE: Years 28 Months 10 Days 5
If less than one day hr. min.

9. Birthplace Colwich / Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation stenographer

11. Industry or business Dodsworth Dictionary Co.

12. Name Bernadette Steffins

13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Anna Strunk

15. Birthplace Colwich / Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Strunk (Strunk)

(b) Address 3911 Washington

17. (a) Burial (b) Date thereof 8-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director H. H. Warrub

(b) Address 644 1/2 N. M. Brown

19. (a) 8/4/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999
(c) City or town. Colwich 14
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day third
year 1941 hour 4:00 minute - A.M.

21. I hereby certify that I attended the deceased from January 14-1941 to August 3 1941.
that I last saw her alive on August 3 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Duration

Due to Pulmonary hemorrhage

Due to Tuberculosis (pulmonary)

Other conditions (Include pregnancy within 3 months of death) 12/10

Major findings: Of operations 12/10

Of autopsy 12/10

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work? (e) Means of injury

23. Signature R. C. Hager, M.D. (M. D. or other)

Address R. C. Hager, M.D. Date signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3965

P. O. Address Kansas City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.